ANESTHESIA PAYMENT GUIDELINES

Only a single payment for anesthetic services will be made for a single operative session. For example, there will be no additional payment made for the services of certified registered nurse anesthetist (CRNA) that may assist or participate with an anesthesiologist in a single operative session.

When anesthetic services are provided primarily by a CRNA, a payment will be made with the use of modifier -NA. The CRNA shall be allowed 65% of the fee schedule allowance.

Payment for anesthesia services is based solely on a dollar conversion unit times the anesthesia value determined for each service rendered. The American Society of Anesthesiologists' Relative Value Guide should be referred to for guidelines and specific anesthesia determination. This guide can be obtained by contacting the American Society of Anesthesiologists at (847) 825-5586.

DOLLAR CONVERSION UNITS

The dollar conversion unit for anesthesia of $57.58 is provided for the total zip code area. This conversion factor applies to CPT-4 codes 00100 - 01999. The appropriate amount will be applied to the anesthesia values as described below.

All anesthesia values are a sum of:

1) **Basic Value** (which relates to the complexity of the service); and
2) **Time Units**; and
3) **Modifying Units** (if any).

Basic Value (and the guidelines for determining Basic Value) for anesthesia can be found in the American Society of Anesthesiologists' Relative Value Guide. In the anesthesia section of the fee schedule rates, the column entitled "BAV" contains the basic values for these codes.

Time Units are added to the Basic Value at a rate of 1.0 unit for each 15 minutes, or fraction thereof, for each hour. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or an equivalent area and ends when the anesthesiologist is no longer in personal attendance (e.g. when the patient can be safely placed under customary post-operative supervision).

Modifying Units are added to the Basic Value and the Time Units to reflect unusual circumstances in the patient's physical status and in the type and intensity of services rendered. Refer to the American Society of Anesthesiologists Relative Value Guide for specific modifiers.

Example:

01382 - Anesthesia for arthroscopic procedure of knee joint.

Conversion Unit	=	$ 57.58
Basic Value	=	3
Time Units	=	8
Modifier	=	0
Anesthesia Fee	=	**$633.38** (57.58 x 3)+(57.58 x 8)+(57.58 x 0)= $633.38

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ASSISTANT SURGEON GUIDELINES

To determine the need for an assistant surgeon, the "2002 Study: Physicians as Assistants at Surgery" shall be consulted. The publication is available from:

The American College of Surgeons
1640 Wisconsin Avenue, NW
Washington, DC 20007
Phone: (202) 337-2701
http://www.facs.org/index.html

When a code is unavailable in the study due to it's release post the study, CMS guidelines have been applied.

Assistant fees are not payable when the hospital provides intern or resident staff to assist at surgery.

In accordance with the above listed publication, each surgical procedure falls into one of three categories almost always, sometimes and almost never.

In the surgical fee schedule rates section, this information is contained in the column entitled "Asst Surg." (A = almost always), (S = sometimes), and (N = almost never).

An assistant surgeon shall be paid for any surgical procedures listed as "almost always" unless the physician agrees that an assistant surgeon is not necessary.

An assistant surgeon shall not be paid for any surgical procedure listed as "almost never" unless the insurer agrees that an assistant surgeon is necessary.

An assistant surgeon may be paid "BY REPORT" for any surgical procedure listed as "sometimes".

A. In the case of elective surgery, a physician shall submit a request prior to surgery including specific statements of necessity of an assistant surgeon.

B. If an insurer intends to deny payment, a review must be performed by a physician.

C. The review should be completed as soon as possible, not to exceed fourteen (14) days after submission of request. Upon completion of review, if a denial is determined, the reviewer or insurer shall forward specific reasons for denial to the physician. Any continued disagreement will be determined by the Workers' Compensation Court.

D. Should an insurer choose to pay without this review, said payment should not be considered agreement of the need for an assistant surgeon. Insurers may use payment information regarding assistant surgeons to present a complaint of over utilization practices to the Medical Advisory Board under R. I.G.L. 28-30-22 (e) (1).

A physician who assists at surgery shall be allowed 20% of the fee schedule allowance for the surgeon for any procedure(s) that would warrant an assistant surgeon. This fee shall only be paid to one primary assistant surgeon.

CASTING AND STRAPPING GUIDELINES

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1. The first cast or traction device is included in the cost of a surgical procedure. Surgical procedures include codes 20000-29999. The costs of materials are included in the service code and charges for codes 29000-29590 are disallowed.

2. The cost of materials for casting or strapping is billable when it is provided as an initial procedure in which no surgery is performed. In addition to the cost of materials, the appropriate level of office visit should be billed when no surgery is performed.

3. A charge for procedure codes 29000-29590 is allowed only when the casting or strapping is a replacement procedure used during the period of follow-up care. The charge for an office visit is allowed only if significant identifiable further services are provided at the time of the cast application or strapping.

4. Codes 29000-29590 include both the application and removal of the cast or strapping.

5. Codes 29700-29799 for cast removals are allowed only when the cast is applied by another physician. These codes are not applicable when the cast is removed by a different physician in the same group or facility.

CHIROPRACTIC SERVICES

- See "Manipulation Guidelines."

FREESTANDING AMBULATORY SURGICAL CENTER AND LICENSED PHYSICIAN OFFICE SETTING PROVIDING SURGICAL TREATMENT (OFFICE OPERATORIES) FACILITY FEE WORKERS' COMPENSATION SCHEDULE

NOTE: This schedule does not apply to ambulatory surgery performed in a hospital.

Freestanding Ambulatory Surgical Center and Office Operatory facility fees shall be paid per the following schedule:

INSTRUCTIONS:

1. Surgical procedure codes have been assigned to one (1) of five (5) surgical procedure code groups.

2. Each surgical code group has been assigned a maximum facility fee.

3. To determine the maximum facility fee, locate the procedure code in a surgical section of the fee schedule rates. Look at the column entitled "ASC." This column contains the surgical procedure group for that code. The Ambulatory Surgical Center or Office Operatory shall be reimbursed no more than the maximum facility fee assigned to the surgical procedure code group.

   Example: A carpal tunnel procedure is performed; surgical procedure code 64721 is classified in surgical procedure code group 2. Therefore, the maximum facility fee for this procedure is $726.17.

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4. The facility fee includes the following:
   - The operating room.
   - The usual and customary drugs and surgical supplies for the procedure.
   - The recovery room.

5. The facility fee does not include the following:
   - Surgeon and anesthesiologist charges.
   - Extraordinary surgical supplies, prosthetics, implant devices or drugs. When billing for these supplies and drugs, the Surgical Center or Office Operatory shall provide the payer with a copy of the invoice documenting the actual cost of these supplies and drugs. The payer shall reimburse the Surgical Center or Office Operatory the cost of these supplies and drugs in addition to the facility fee.

6. Fee "Unbundling" and uniform definition for surgical procedures:
   - Procedures that are an integral part of the main operation should be considered as necessary adjuncts, not separate entities. Surgical procedures shall be billed based upon the uniform definitions found in the the most current version of the American Academy of Orthopedic Surgeons "Global Service Data for Orthopedic Surgeons". (The "Medicare global fee period" included in each definition will not be used.)

7. Multiple Surgeries: Payment for multiple surgeries billed in accordance with the unbundling rule above will be as follows:
   - 100% of the facility fee for the primary procedure
   - 50% of the facility fee for the secondary procedure
   - 30% of the facility fee for the third, fourth, or fifth procedures.

Surgical Procedure Code Groups	Maximum Facility Fee
1	$ 589.70
2	$ 726.17
3	$ 828.83
4	$ 969.05
5	$ 1,149.68

MANIPULATION GUIDELINES

- Manipulation codes include X7260 and X7261. (see last page(s) of codes for fees)

- Chiropractic and Osteopathic manipulation codes were removed from the Rhode Island Worker's Compensation Fee Schedule.

- Manipulation codes shall be billed only by physicians (i.e. medical doctors, chiropractors, and osteopaths).

- A physician shall charge for either a manipulation procedure (X7260 - X7261) or an evaluation and management procedure on a single date of service.

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- Physician services shall not be coded using the physical therapy codes (X7001 - X7005). Those physical therapy codes shall be used to code for services provided by physical and occupational therapists and aides. Massage therapists shall also use these physical therapy codes.

- A physician who is also a registered physical, occupational, or massage therapist shall charge for either: (a) a physical therapy procedure; (b) a manipulation; or (c) an evaluation and management procedure on a single date of service.

MEDICAL SERVICE GUIDELINES (Codes 90000 – 96999)

PROFESSIONAL/TECHNICAL COMPONENT FEE

Some medical procedures (90000 - 96999) may be divided into professional (26/PC) and technical (27/TC) portions and completed by separate parties. When applicable, the payment for codes 90000 - 96999 may be billed and reimbursed separately. Payment shall be made at 50% of the fee schedule allowance for the technical portion (TC/27) and at 50% of the fee schedule allowance for the professional portion (26/PC). Under no circumstance shall more than 100% of the fee schedule allowance be reimbursable in aggregate.

CODES 90801 - 90915 ONLY

The Department of Labor and Training has specified that when procedures defined under CPT-4 codes 90801 - 90915 (including biofeedback) are performed by a professional other than a medical doctor, the payment rates below will apply.

In order to distinguish the professional, a modifier should be used with the code at the time that claims are submitted. The specific modifier to be used for each professional is noted below.

MEDICAL PROFESSIONAL	MODIFIER CODE	PAYMENT RATE (% OF FS AMOUNT)
Medical Doctor	A	100%
Ph.D. or Psychologist	B	75%
Master Level Social Worker	C	50%
Masters Level Nurse	D	50%
Other Medical Specialist	E	50%

PATHOLOGY AND LABORATORY GUIDELINES

AUTOMATED MULTI-CHANNEL TESTS

The following list contains examples of those tests that can be and are frequently done as groups and combinations ("profiles") on automated multi-channel equipment. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting.

Alanine aminotransferase (ALT SGPT)
Albumin
Aspartate aminotransferase
Bilirubin, direct

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Bilirubin, total
Calcium
Carbon dioxide content
Chloride
Cholesterol
Creatinine
Glucose
Lactate dehydrogenase (LD)
Phosphatase, alkaline
Phosphorus (inorganic phosphate)
Potassium
Protein, total
Sodium
Urea Nitrogen (BUN)
Uric Acid

PROFESSIONAL/TECHNICAL COMPONENT FEE

Most pathology and laboratory codes are automated and will not necessitate or warrant a separation of the technical and professional fees. When applicable, the payment for the professional (26/PC) and technical (27/TC) portions for codes 80000-89999 may be billed and reimbursed separately. Payment shall be made at 50% of the fee schedule allowance for the technical portion (TC/27) and at 50% of the fee schedule allowance for the professional portion (26/PC). Under no circumstance shall more than 100% of the fee schedule allowance be reimbursable in aggregate. Any laboratory or pathology charges performed in a hospital setting covered under a cost to charge ratio are assumed to be the full procedure and a separate professional component billing would not be allowable.

PHARMACY CHARGES GUIDELINES

MEDICAL PROVIDER:

Pharmaceuticals may be billed through a provider setting only if the provider administers the pharmaceutical (ex: injectibles). These pharmaceuticals will be reimbursed at average wholesale price (AWP) acquired through any number of databases including but not limited to the Medispan database. Pharmaceuticals that have been provided as free samples to the medical provider can be given to the patient when appropriate, but these pharmaceuticals are not reimbursable separately.

HOSPITAL:

The cost to charge ratio of the hospital should be applied where appropriate. When the hospital provides outpatient services that do not fall under the cost to charge ratio, they should be reimbursed according to the guidelines documented in the pharmacy section below.

PHARMACY:

All pharmaceutical billing should include the appropriate National Drug Code for the drugs supplied and the exact quantities supplied. The pharmacy should be reimbursed at a mark-up over the cost of the drugs. Drugs shall be reimbursed at up to 120% of the AWP. The AWP can be acquired through any number of

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databases including, but not limited to, the Medispan database. If there is a dispute regarding the AWP allowance, the pharmacy can send the actual invoice for the supply. In these situations, the pharmacy will be reimbursed at up to 120% of the actual cost of the drugs provided to the patient. If the pharmacy is unable to determine the actual cost of the drugs, the payer has the right to research other pharmacies to find the market value of that drug and to negotiate a reasonable and customary rate with the provider.

MAIL ORDER:

Mail order pharmaceuticals are subject to the Pharmacy guidelines documented above.

PHYSICAL THERAPY & OCCUPATIONAL THERAPY EVALUATIONS & SERVICES

Most of the Physical Medicine codes have been deleted from the fee schedule. These modalities and procedures have been replaced by two levels of evaluation services and three levels of treatment services. These services are defined in detail below.

Codes (X7001 - X7005) shall be used to code for services provided by physical and occupational therapists and aides. Massage therapists shall also use these physical therapy codes.

The following physical therapy codes are all inclusive.

X7001: Comprehensive Evaluation

Key items would include:

- A detailed history
- A detailed examination
- A medical/rehabilitation decision making of low to moderate complexity.
- Documentation of a detailed evaluation, establishment of problem list, treatment goals, and a detailed treatment plan.
- Only appropriate for an initial patient examination

Contributory items would include:

- Case management and coordination of care with other providers or agencies consistent with the nature of the problem.
- Usually, the presenting problems are of moderate severity.

X7002: Limited Evaluation

Key items would include:

- Established patient reassessment or a new patient with a limited (or focused) problem.
- A problem focused history
- A problem focused examination
- Straight forward decision making
- Documentation of a problem focused evaluation, establishment of problem list, treatment goals, and a detailed treatment plan.

Contributory items would include:

- Case management and coordination of care with other providers or agencies consistent with the nature of the problem.

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- Usually, the problems are focused and of a low to moderate severity.

X7003: Comprehensive Treatment

Key factors:

- Face to face patient interaction for prolonged periods for the purpose of providing hands-on care, (excluding the application of passive modalities), creating or changing exercise programs, etc.
- Initial instruction or extensive rehab on isokinetic or strengthening equipment (capital equipment vs. hand held or cuff weights).
- Face to face interaction with patient for the purposes of education, addressing patient concerns, discussion of rehab program progression, work status, etc.

Contributory factors:

- Patient injuries and problems are usually complex, requiring nearly all interactions to be done 1:1 basis.
- There is often a need for frequent rehab decisions (judgments) during the treatment sessions.
- Treatment sessions will be for a minimum of 45 minutes.
- Case management consistent with the severity of the problems.

X7004: Expanded Treatment

Key factors:

- Face to face patient interactions for moderate periods of time for the purpose of providing hands-on care, (excluding the application of passive modalities), creating or modifying exercise programs, etc.
- Rehab using isokinetic or strengthening equipment (capital equipment vs. hand held or cuff weights).
- Occasional (or less frequent) face-to-face interactions with patient for the purposes of education, program progression, discussion, work status, etc.

Contributory factors:

- Patient has less complex injuries or injuries that have begun to resolve.
- Treatment sessions will be for a minimum of 30 minutes.
- Case management consistent with the severity of the problems.

X7005: Limited Treatment

Key factors:

- Face to face patient interactions for short periods of time for the purpose of providing focused treatment, modifying an established exercise program, or the application of a modality.
- **Note:** Length of time the modality is used, example 30 min. ultrasound, does not add to the total treatment time or the complexity level of the treatment.
- Rehab with or without the use of non-capital equipment (e.g. theraband, hand held weights, etc.)

Contributory factors:

- Patient problem is usually focused.
- Case management as needed.

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PHYSICIAN ASSISTANT, REGISTERED NURSE FIRST ASSISTANT AND NURSE PRACTITIONER GUIDELINES

Physician Assistants, Registered Nurse First Assistants and Nurse Practitioners may not bill for services in hospital inpatient, emergency room, and ambulatory surgery settings if the costs associated with those providers have been included in the costs that were used to determine the inpatient, emergency room, and ambulatory surgery Workers' Compensation hospital reimbursement rates.

EVALUATION AND MANAGEMENT SERVICES

A physician assistant or nurse practitioner shall be allowed 80% of the fee schedule allowance for evaluation and management services provided a signed report details the findings of the exam. The CPT level billed must be supported by the signed report.

ASSISTANT SURGEON

A physician assistant or registered nurse first assistant who assists at surgery shall be allowed 80% of 20% (16%) of the fee schedule allowance for the procedure(s). A fee for assistant surgeon shall only be paid to one primary assistant surgeon.

OTHER SERVICES

A physician assistant or nurse practitioner shall be allowed 80% of the fee schedule allowance for any other services performed within their license or certification.

MODIFIERS

When billing for services provided by a physician assistant, use the modifier -PA.

When billing for services provided by a registered nurse first assistant, use modifier -FA.

When billing for services provided by a nurse practitioner, use the modifier -NP.

RADIOLOGY GUIDELINES

A. PROFESSIONAL/TECHNICAL COMPONENT FEE

1. A professional component fee (PC/26) and a technical component fee (TC/27) shall only be payable once for any radiological procedure. A physician will not be paid for a consultative interpretation.
2. When applicable, the payment for the professional (26/PC) and technical (27/TC) portions for codes 70000 - 79999 may be billed and reimbursed separately. Payment shall be made at 67% of the fee schedule allowance for the technical portion (TC/27) and at 33% of the fee schedule

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allowance for the professional portion (26/PC). Under no circumstance shall more than 100% of the fee schedule allowance be reimbursable in aggregate. Any radiology charges performed in a hospital setting covered under a cost to charge ratio are assumed to be the full procedure and a separate professional component billing would not be allowable unless clearly documented by the hospital and unless separation of professional billing was standard hospital practice at the time of the cost to charge reimbursement rate determination.

B. DUPLICATION OF X-RAYS

1. Every attempt should be made to minimize the number of x-rays taken. The attending doctor or other person or institution having possession of x-rays which pertain to the patient that are deemed to be needed for diagnostic or treatment purposes shall make these x-rays available upon request.

2. The insurer or employer shall reimburse a physician or facility a reasonable fee to be set by the Department of Labor for providing a copy of the x-ray. The current maximum rate to be billed is $18.78 per x-ray copy.

SCARRING, LOSS OF USE, AND MAXIMUM MEDICAL IMPROVEMENT (MMI) EXAM GUIDELINES

The following codes are to be used in lieu of Evaluation and Management codes for the specific workers' compensation examination and reporting functions listed below. These services are defined in detail below.

X9001 End Result Exam

Purpose: To Determine if scar(s) have reached an end result.

- This exam should generally be performed by the treating physician and should not be charged with an Evaluation and Management Code on a single date of service.
- Examine scar and provide a written determination as to whether the healing has reached an end point.

X9002 Loss of Use Exam

- This exam should generally be performed by the treating physician and should not be charged with an Evaluation and Management Code on a single date of service.
- Exam Requires:
  1. Maximum Medical Improvement (MMI) determination. If patient not at MMI – no Loss of Use Report is allowed.
  2. Loss of use rating in accordance with X9003.

X9003 Loss of Use Report

- To be completed if patient determined to be at Maximum Medical Improvement after an X9002 loss of use exam.
- Impairment rating should be based on loss of function of an extremity.
- Report must include:
  - Narrative History
  - Current clinical status, i.e.; MMI
  - Diagnostic study results

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- Diagnosis
- Calculation of Impairment Rating:
    1) Compare the medical findings with the impairment criteria listed within the *AMA Guides to the Value of Permanent Impairment* and calculate the appropriate impairment rating. Discuss how specific findings relate to and compare with the criteria described in the applicable *Guides* chapter. Refer to and explain the absence of any pertinent data and how the physician determined the impairment rating with limited data.
    2) Discuss how the Impairment Rating was calculated:
        a) Include an explanation of each impairment value with reference to the applicable criteria of the *Guides*. Combine multiple impairments for an extremity impairment.
        b) Include a summary list of impairments and impairment ratings by percentage, including calculation of the extremity impairment.

MULTIPLE EXAMS - SCARRING, LOSS OF USE, AND MMI

Whenever possible, these exams should be performed and reported in one office visit and for one charge. If for some reason these reports require more than one exam, the following rules shall apply.

Payment for multiple exams same anatomical site:
- 100% payment for first exam
- No payment for additional exams or reports

Payment for multiple exams different anatomical sites:
- 100% payment for first exam and report
- 50% payment for second exam and report
- No payment for additional exams or reports

SURGICAL GUIDELINES

INCLUSIVE SURGICAL POLICY

1. The maximum reimbursement for a pre-operative surgical visit for an established patient shall be $71.37. The CPT level of service must be supported by office notes.

2. The surgical procedure itself.

3. Local anesthesia, such as infiltration, digital or topical anesthesia. (For regional anesthesia - modifier codes should be used by the physician in accordance with CPT rules.)

4. In-patient hospital visits. When extenuating circumstances require a patient to remain hospitalized beyond a standard length of stay, charges for in-patient hospital visits may be submitted for individual consideration.

5. First routine post-operative office visit.

FEE "UNBUNDLING" AND UNIFORM DEFINITION FOR SURGICAL PROCEDURES

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Procedures that are an integral part of the main operation should be considered as necessary adjuncts not separate entities. Surgical procedures shall be billed based upon uniform definitions found in the most current version of the American Academy of Orthopedic Surgeons "Global Services Data for Orthopedic Surgeons". (The "Medicare global fee period" included in the definition will not be used). Further information on this publication is available at:

AAOS
6300 North River RoadRosemont, Illinois 60018
(847) 823-7186
http://www.aaos.org/

MULTIPLE SURGERIES

Payment for multiple surgeries - same incision and/or anatomical site, billed in accordance with the unbundling rule above, will be as follows:

- 100% of the practitioner payment amount for the primary procedure
- 50% of the practitioner payment amount for the secondary procedure
- 30% of the practitioner payment amount for the third, fourth, or fifth procedures.

Payment for multiple surgeries - different incision and/or anatomical site, billed in accordance with the unbundling rule above, will be as follows:

- 100% of the practitioner payment amount for the primary procedure
- 50% of the practitioner payment amount for the second, third, fourth, or fifth procedures.

The above multiple surgeries rule shall not apply to an emergency surgery. Emergency surgery is surgery that is generally performed within twenty-four (24) hours of a traumatic injury. Charges for an emergency surgery shall be submitted for individual consideration. Emergency surgery is subject to the above inclusive surgical policy and fee unbundling and uniform definition for surgical procedures.

VOCATIONAL REHABILITATION INITIAL EVALUATION

The following codes are to be used for charging for vocational Evaluation and Management services. These services are defined in detail below.

XV001 Limited Initial Vocational Evaluation

Key Factors:

- Review of injured workers' medical records
- Scheduling of injured workers' initial evaluation with the vocational rehabilitation counselor
- Face to face initial vocational interview
- Initial vocational rehabilitation report with recommendations based upon hierarchy of vocational rehabilitation

Contributory items would include:

- Injured worker has limited work history
- Clearly defined transferable skills

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- Physical restrictions defined by medical providers are of low severity

XV002 Expanded Initial Vocational Evaluation

- Review of injured workers' medical records
- Scheduling of injured workers' initial evaluation with the vocational rehabilitation counselor
- Face to face initial vocational interview
- Transferable skills analysis completed
- Initial vocational rehabilitation report with recommendations based upon hierarchy of vocational rehabilitation

Contributory items would include:

- Injured worker has a moderate work history
- Minimally defined transferable skills
- Physical restrictions defined by medical providers are moderate

XV003 Comprehensive Initial Evaluation

- Review of injured workers' medical records
- Scheduling of injured workers' initial evaluation with the vocational rehabilitation counselor
- Extended initial vocational interview
- Transferable skills analysis completed
- Initial vocational rehabilitation report with recommendations based upon hierarchy of vocational rehabilitation

Contributory items would include:

- Injured worker has a complex work history
- No clearly defined transferable skills
- Physical restrictions defined by medical providers are complex

OUT OF STATE SERVICES

Out of state medical services on a Rhode Island workers' compensation claim are subject to the Rhode Island Fee Schedule rules and rates. Should the state where the services are performed publish enforced state specific hospital or provider rates for worker's compensation, reimbursement may be made at these rates for Rhode Island workers' compensation claims.

RHODE ISLAND WORKERS' COMPENSATION HOSPITAL RATES

The inpatient, emergency room and ambulatory surgery adjustments to charges are effective for all hospital services provided on or after July 1, 2007.

HOSPITAL CHARGES SHOULD BE MULTIPLIED BY THE APPROPRIATE PERCENTAGE LISTED BELOW.

Example:		$1000.00	Butler Inpatient Charge
	x	54.39%	Inpatient adjustments to charges

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$ 543.90 Amount Paid

Hospital	Inpatient Adjustment to Charges	Ambulatory Surgery Adjustment to Charges	Emergency Room Adjustment to Charges
Butler	54.39%	N/A	N/A
Kent County	43.58%	39.00%	34.41%
Landmark	49.59%	50.98%	35.31%
Memorial	60.07%	42.74%	87.42%
Miriam	38.73%	24.93%	16.77%
Newport	70.91%	40.78%	73.74%
Rhode Island	44.94%	45.30%	36.85%
RI Rehab Hospital	82.62%	N/A	N/A
Roger WMS.	56.72%	46.20%	25.67%
St. Joseph	39.61%	32.41%	23.00%
South County	75.16%	41.40%	38.43%
Westerly	58.10%	36.10%	34.36%
Women & Infants	41.71%	53.07%	100.00%

Rates are based on approved cost finding methodology and other statistical data furnished by each hospital through the Hospital Association of Rhode Island for the period indicated.

All other outpatient services are subject to the rules and rates of the Rhode Island Workers' Compensation Fee Schedule.

DISCLAIMER

The Rhode Island Workers' Compensation rates contain codes that may or may not be related to a workers' compensation claim. Inclusion of a code in the fee schedule rates does not guarantee compensability of that service.

INQUIRIES

All questions and/or comments should be directed to Matt Carey at the Rhode Island Department of Labor and Training at (401) 462-8127.

Fee Schedule Database Fields

COLUMN — **DETAIL**

Code: CPT-4 code or RI Fee Schedule Code. More detail on CPT-4 codes is available in the American Medical Association's 2004 Physicians' Current Procedural Terminology. The AMA can be reached at (800) 621-8335.

BAV: The Basic Anesthesia Value for a procedure. This column is only populated in the anesthesia code section of the rates (00000 - 09999).

Rate: The dollar value for the "Code" which includes both the professional and technical portions of the medical procedure. "BR stands for a "By Report" procedure. These

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procedures are either too new to establish the rate or are generic codes that are used in rare and unusual situations. A "BR" needs to be given individual consideration when determining the reimbursement rate. A rate of $0.00 indicates this code is not reimbursable separately.

TC (27): The dollar value for the "Code" which reflects the technical portion of the medical procedure. These services should be billed with a "TC" modifier. "BR stands for a "By Report" procedure. A "BR" needs to be given individual consideration when determining the reimbursement rate. A rate of $0.00 indicates the technical portion of the "Code" is not reimbursable separately. This column is only populated in the radiology and laboratory sections of the rates (70000 – 89999).

PC (26): The dollar value for the "Code" which reflects the professional portion of the medical procedure. These services should be billed with a "26" modifier. "BR stands for a "By Report" procedure. A "BR" needs to be given individual consideration when determining the reimbursement rate. A rate of $0.00 indicates the professional portion of the "Code" is not reimbursable separately. This column is only populated in the radiology and laboratory sections of the rates (70000 – 89999).

Asst Surg: This column lists the appropriateness of an assistant surgeon being charged in addition to the primary physician by category. According to the Rhode Island Fee Schedule, the three possible categories each surgical procedure can fall into are (A) almost always, (S) sometimes and (N) almost never. See the fee schedule rules for more detail. This column is only populated in the surgical code section of the rates (10000 - 69999). Any code not defined, with no "like" procedures to compare to, should follow (S) sometimes guidelines.

ASC: This column defines the ambulatory surgical procedure code group of the "Code." Surgical procedure codes have been assigned to one (1) of five (5) surgical procedure codes groups. Each surgical code group has been assigned a maximum facility fee. See the fee schedule rules for more detail. This column is only populated in the surgical code section of the rates (10000 - 69999).

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